« « The » »

MEDICAL MISSIONARY

Dürer copy.

GLORIA IN EXCELSIS DEO—PAX HOMINIBUS BONAE VOLUNTATIS

Vol. V DECEMBER, 1931 No. 3

A Vision of Bethlehem

One night when the home lights of Heaven
Were twinkling on high,
And a breeze like the whispering of angels
Went timidly by,
And the peace that comes only at Christmas
Hung down from the sky.

A vision came out of the shadows
And smiled on my soul,
And filled it with love and with longing
For a glimpse of the Goal,
Where the death-knells of sin and of sorrow
Eternally toll.

I knelt at the door of a stable
In a far away land,
And bowed down my head for a blessing
From a Babe's little hand,
And a smile from the Mother who bore Him
That was tender and bland.

And even the beasts in the stable
Went down on their knees,
To worship the Babe Who was ruler
Of earth and of seas;
And the voices of myriad angels
Came in on the breeze.

And one who was weary from walking
Stood silently there,
And looked from the Babe to the Mother—
A look full of care—
An old man with gloom on his forehead
And the snow in his hair.

And gazing from one to the other
Of the Heaven-sent Three—
The old man, the frail, gentle Mother,
And the Babe on her knee—
Came peace, and departed all doubting,
All dread and all dree.

And tonight in my dreams of the chosen
I walk where they trod,
But between me and them and the stable
The palm branches nod:
And I plead for the peace of my vision,
O Baby of God!

And I pray Thee, O Mother of Jesus!
O Virgin most fair!
And I pray Thee, O Help of the Homeless
With the snow in thy hair!
That when God bids me come through the shadows,
Such peace be my share!

BRIAN O'HIGGINS.

The MEDICAL MISSIONARY

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Gloria in Excelsis Deo

GLORIA IN EXCELSIS DEO! Soon these words brought to earth by heavenly hosts will resound in our churches more solemnly and ring in our hearts more meaningly than at any other time of the year.

GLORIA IN EXCELSIS DEO! Sublime prayer first taught to ignorant shepherds keeping night watch over their flocks in the plains of Bethlehem by choirs of angels robed in dazzling light.

GLORIA IN EXCELSIS DEO! Trumpeted out into the stillness of the night over a lonely stable outside the City of David—which was so busy and crowded that it could not shelter a mother so young and so frail and so in need of special consideration.

GLORIA IN EXCELSIS DEO! In praise of a helpless infant lying in a manger wrapped in swaddling clothes, lovingly mothered by a mere maiden and watched by a simple workman.

GLORIA IN EXCELSIS DEO! Now jubilantly repeated by voices without number over the whole globe wherever Christian hearts are beating.

GLORIA IN EXCELSIS DEO! Not yet uttered by millions and millions of human beings because the tidings of the most important event that ever occurred in the world, namely, the Coming of God Himself as Man amongst us, has not as yet reached or stirred them.

GLORIA IN EXCELSIS DEO! May the day dawn soon when Christmas is to all a day of unsurpassing joy and gratitude because it is the birthday of Christ, the King, the Redeemer, and the Light of the world and our reward exceeding great.

GLORIA IN EXCELSIS DEO! Now and forever and ever.

Shepherd boy from Darjeeling To such as him. the Gloria in Excelsis Deo was first proclaimed

This little lady in her Sunday best would like to tell you in the name of the little children whom you have enabled us to help: Merry Christmas and God Bless You

Our Christmas Wish

We wish all our Readers and Friends and Benefactors most heartily and sincerely the joys and blessings of Christmas. During Advent we will pray especially to the Giver of all good gifts, for the realization of our wishes. This is our only way to show our appreciation of and gratitude for the cooperation of our Benefactors who have helped us so generously and faithfully and often at the cost of great sacrifices to carry on our work for the sick.

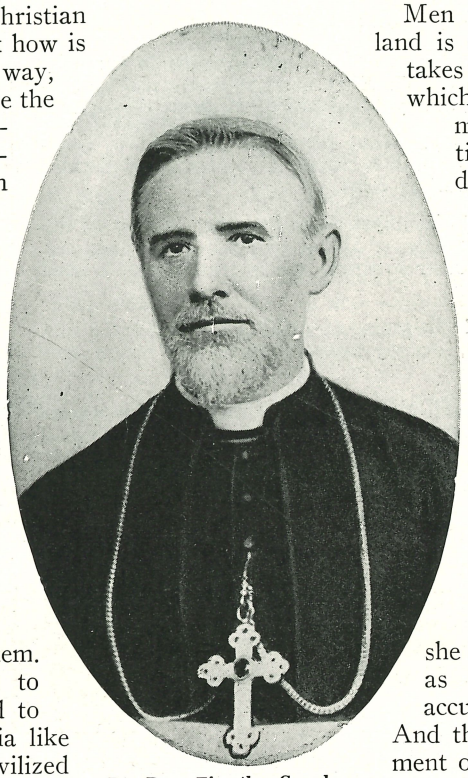
Merry Christmas to you and yours!

THE MEDICAL MISSIONARY IN THE LAND OF THE PURDAH

By Rt. Rev. T. Crowley, C.S.C., *Bishop of Dacca, Bengal*

I HAVE just read the inspiring appeal by Dr. Joanna Lyons in the August number of The Medical Missionary. As one who has lived close on twenty-five years in daily intimacy with social conditions in this land of the purdah, I feel in no small measure qualified to appreciate fully the cause on behalf of which Dr. Lyons pleads.

The present Holy Father urges missionaries "to plant the Church" in non-Christian lands. One may reverently ask how is this to be done, in any adequate way, in a country such as India where the influential half of the population, the women behind the purdah, are virtually out of reach of the Gospel message. I should on no account wish to exaggerate facts, but it does seem a conservative statement that the "planting of the Church" in India will indeed be greatly retarded till an avenue of appeal is found to win the womanfolk, that is, the *homes* of the people. When one recalls the glorious part played by the Roman matrons, "and of noble women not a few," one realizes something of the loss to the Church in India that is created by the purdah system. There is a growing agitation to abolish the evil of purdah and to emancipate the women of India like their sisters throughout the civilized world. But that day of freedom is distant. Many Hindus, and possibly not the least wise, are of opinion that the protection of the veil had better remain till men's manners improve. Of course, among the twenty-three millions of musselmen in Bengal the thought of removing the purdah is not even suggested. And the pathetic feature of the system is that the victim hugs her chain. Hers is the bliss of ignorance. The more secluded her enclosure, the happier she feels. She is brought up in the belief that strict purdah is the measure of her husband's esteem of her.



Rt. Rev. Timothy Crowley, C.S.C.

In India the woman problem frustrates the efforts of the missionary as no other one cause. Many men would feel brave enough to face for conscience sake the persecution of caste, but their courage fails at the thought of the domestic ordeal that would inevitably follow conversion. A Hindu may believe in one God, in a thousand gods or in no god. As long as he complies with the rules of caste externally, and with family observances, which are invariably of a religious character, his position in society and family is not questioned. The moment, however, that he declares himself Christian, he loses everything. The sacrifice involved in most instances is heroic. The convert finds the prophecy literally fulfilled that his cruelest enemies are those of his own household.

Men will tell you frankly that the land is overrun with superstition. It takes its beginning in the home, which is the very sanctuary of the most senseless beliefs and practices. Take, for instance, the detailed cruel ceremony that seals the fate of a sonless widow. It is all based on a wrong theology, yet clung to with all the conscientiousness due a divine revelation. The widow may have been the most devoted of wives, yet now she must accept as her own the guilt of her husband's death. The natural causes, such as c h o l e r a, small-pox, black-water fever, explain nothing. It is the widow alone who is guilty, and a life of expiation becomes her lot. As a bride, she was the idol of the family; as a widow, she has become accursed and is treated as such. And the sad thing is that this treatment of the afflicted woman (it may be a mere child or girl widow) is a religious observance. She accepts it resignedly. She believes herself loathsome to gods and men because others have told her so. Mr. Gandhi and other leaders scarcely less eminent have fought against the evils of caste, enforced widowhood, child carriage, untouchability and all the other outgrowths of superstition. The few emancipated women plead on behalf of their unfortunate sisters. But the result of all this well-meaning effort is practically negligible. Protestant missionaries distribute thousands of bibles annually. Here, again, well-meaning effort has borne little fruit. A bible, however holy a book, is not of great use to a community of women where probably not more than 1 per cent is literate. In the Moslem woman world the proportion is even less; it stands at two per thousand of the population.

Since, then, the Gospel cannot be preached to the women of Bengal nor read by them, it has to be acted out on their behalf. This meritorious

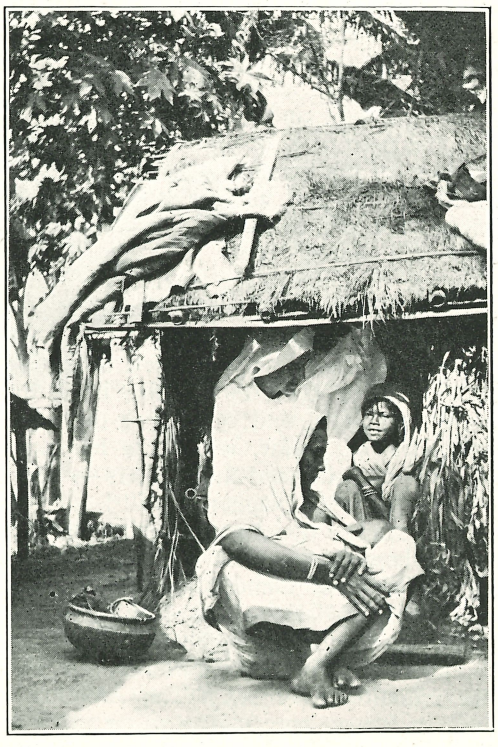
Sister M. Helen, R.N., and Sister M. Laetitia, R.N., who are engaged in maternity and child welfare in Dacca, Bengal. The city has a hundred thousand inhabitants. Four thousand babies are born a year. Of these one thousand die during the first year of life

apostolate is the peculiar privilege of the Catholic Medical Missionary. In places where no man may enter, she is always welcome. Recently a Sister told me a very beautiful incident characteristic of the innate courtesy of the Indian woman, when not obsessed by superstition. The Sister, in her house-to-house visitation, arrived at a home in which dwelt a young widow, who was just about to break a ceremonial fast that had lasted 36 hours.

> "Pardon me," said the Sister. "Take your meal; I can wait."
>
> "No! No!" replied the young widow, putting the plate of rice aside. "I can eat at any time, but I cannot listen to your words at any time."

This incident is not exceptional. A veteran missionary nun, who has visited in her long career thousands of Hindu and Moslem homes, assured me that she had never been refused admission to any home in Bengal. This is a beautiful record in a land of so much caste exclusiveness. How the people remember these visits! Years after the Sister may have left the Station, and indeed may hav long passed to Heaven, her kindly visits will be remembered and her name, or at least a syllable of it, will be treasured in the grateful memories of the womanfolk. Though the Medical Missionaries have worked in Dacca only two years, I am confident that there are not two women in the city more respected—venerated is the proper word. Chivalry, as the purdah system bears witness, is not a characteristic trait of the oriental man. One thing, however, is certain that not one of the 50,000 men of Dacca town will fail in courtesy to the Sisters. This was beautifully proved in the recent communal looting and rioting in the city. The Sisters, in their rounds of mercy to the sick, moved through the lanes of Dacca unmolested. Though upward of 20,000 persons, chiefly women, fled to villages for safety, the Sisters did not miss a call, night or day, during the six weeks of the reign of terror. I need not point out what a happy reaction on the work of the Mission generally comes from this apostolate of the Sisters to the homes of the sick and afflicted. When men would not listen, even to the words of Christ, He appealed to His works: "Believe for the works sake." St. Paul says that faith comes by hearing. The great Gift will come to Dacca by *seeing,* seeing the Gospel enacted by the Sisters in a Christlike way. "He went about doing good, healing all manner of diseases."

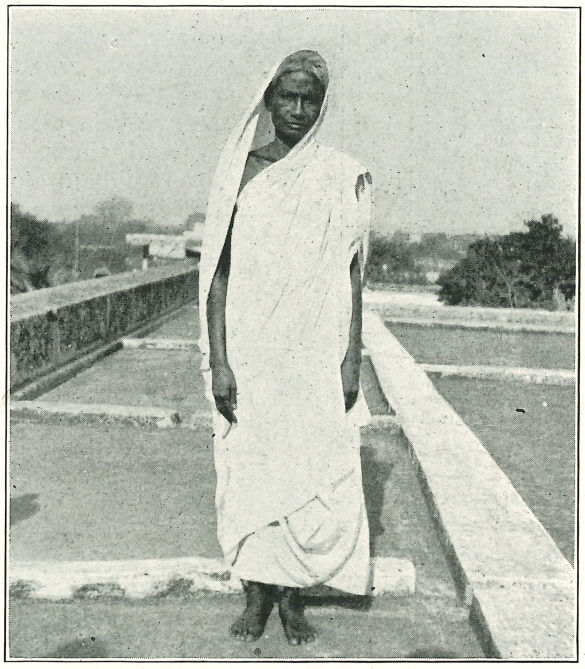
While attaching to the medical mission of the Sisters its truly vast importance "in planting the Church," I should not wish any one to underestimate the educational apostolate of our Sisters in the Dacca Mission. Every hour of the day not taken up in the class room, in the creche, in the



Bethlehem in Dacca. Our Sisters visit homes like these every day and are happy to do it.

care of orphans, is spent in the dispensary or in visits to the sick in Catholic and in non-Christian homes. Holiday seekers urge the change of the calendar. The Sisters of the Dacca Mission will sincerely welcome the year of thirteen months.

Little wonder that the Sisters feel impatient. There are only twenty-eight Sisters in the whole of the Dacca Mission which counts a population of twelve million unbelievers. Who will question the extent of the harvest? But the laborers! In no age of the Church have women been found wanting to play their part in God's service. Nor will they be found wanting now. When I see the wives of European officials, magistrates, police, soldiers, merchants, the wives of the plain covenanted European workmen, come to live in India, and lead a life of monotonous routine, camping rather than residing here, I think of St. Francis Xavier's retort to those who would dissuade him from going to China: "If merchants go to China for silks and precious stones, shall I be afraid to go there for the glory of God and the sake of precious souls?" St. Francis went to China. Similarly, when young Catholic women realize the welcome awaiting them in India, especially when they understand the need and opportunities of the trained medical worker and her intimate part in planting the Church among this fine people, volunteers for the Mission front will not be wanting. The thought of the precious opportunities, and the infinite number of them daily, will prompt generous souls, desirous of doing great things for God, to sacrifice home and all that home implies, and consecrate their lives to labor in the field afar, where the harvest is so great and promising and the workers so very few.



Hindu widow. Her parents were rich. She was betrothed when a little girl but her bridegroom died soon. She grew up with the stigma of widowhood upon her, despoiled of honor and jewels, obliged to spend her life in menial tasks

I do not wish to exaggerate still less to appear censorious, but is it not pathetic that the Catholic Church whose faith works so admirably through medical charity at home, should be represented in the Dacca Mission with only two qualified Catholic women to minister in the Christ-like way that only a Catholic medical woman can minister, to six million of her sex. The American missionary in Bengal entertains a great and glorious feeling when year by year he learns of America leading the nations of the Catholic world in offerings for the Propagation of the Faith. The Dacca Mission, in particular, has very many reasons to be grateful to America for its generosity in men and money. We are confident that when the true nature and scope of the woman's apostolate is understood, recruits will multiply manifold. Five American Sisters of Holy Cross in the Dacca Mission pioneer in the educational apostolate for girls and only four American Sisters represent, in a qualified way, the medical ministry of the Church in this land of caste and purdah. When St. Francis Xavier realized, as only Saints realize, the possibilities for God's work in India, he wrote that should he ever return home he would go to the universities of Europe and explain to the doctors and students there how precious would their services be in India. I have no doubt but the Saint, if he visited Europe and America today, would include the convents and hospitals in his itinerary. And generous volunteers would not be wanting.

SAINT FRANCIS XAVIER

This coming year Goa will be privileged again, by having the body of St. Francis Xavier exposed for the veneration of the inhabitants of Goa and pilgrims from all over India. Many Goans visit their native lands regularly every 10 years on the occasion of the Exposition of the relic. The body of the Saint is not very shrivelled. The pilgrims kiss the feet, often miracles are reported. Not rarely non-Christians also visit the Shrine with great confidence and are rewarded for it by some favor granted.

THE GENEROUS DEED

The grace from God I'm asking,
Dear soul, for you most of all,
Is the love that cares
And the heart that dares
To follow the Master's call.

For the souls He calls are many—
Ah! the souls that heed are few—
But His Heart can lead
To the generous deed
The generous heart of you.

—Neil Boyton, S.J.

A CITY ABOVE THE CLOUDS

A Visit to Darjeeling by SISTER M. LAETITIA FLIEGER, R.N.

The Journey

THROUGH endless fields of rice and jute, groves of banana trees, past tiny bamboo villages, rushed the train. Every mile traversed was a replica of the one before. Well are the plains of Bengal so named—not one hillock is to be seen from morning till night. At last the long hot day came to an end and we boarded the steamer to spend a couple of hours of comparative coolness on the smooth waters of the "holy Ganges." Once more the train journey was resumed, through endless fields of rice and jute, until next morning ranges of distant mountains met our gaze.

We passed through the famous jungle of the Serai—the home of elephants, tigers and other wild beasts. Eagerly we tried to catch a glimpse of them through the dense forest and thick underbrush but nothing fiercer than a water buffalo was to be seen.

Then up the mountain side we went on a diminutive train, round peak after peak, mounting steadily every minute, the little engine panting as if its heart would break. A man sat in front and threw sand on the lines to prevent our slipping back to an untimely end. Here and there, the line approached the extreme edge of a precipice and with horror we looked down into a yawning abyss.

TIBETAN MENDICANT

Darjeeling

At last, Darjeeling! Seven thousand feet above the sea level! Built on the mountain side, it is a wonder that some of the houses do not go toppling down the steep slopes. Most of them are painted white or constructed of a light colored stone. All have tin roofs, painted red. Nestling among the green, very green, pine trees, they make a beautiful picture when the sun shines on them. Not mere houses but fairy palaces with windows of diamonds and ruby roofs in a setting of emeralds. Unfortunately all this beauty is hidden by the clouds for several months of the year. These rest on or below the city, completely shutting it off from the outside world. A heavy rainfall during the monsoon effectually blots out the entire landscape. A government official, resident in Darjeeling for some years, on being asked how he liked it replied, "Darjeeling is like this—every morning for six months I walked to my office, and one day, across the road, appeared a house I had never seen before." Many years ago land slides were of frequent occurrence. One night a priest, thinking he heard cries and noises, got up to investigate. He walked around for a short time and, as all seemed quiet, he prepared to return when he saw the ground open and a huge avalanche of earth, stones, houses and people carried madly down the mountain side. Fortunately, he happened to be standing on a firm piece of ground.

About the second day of our visit we were caught in a rain storm and lost our way. After walking for some time, we came to a cemetery and found there a *chaukidhar* (watchman) who undertook to see us safely home. Before doing so, however, he insisted on showing us the graves of some land-slide victims. Not knowing our way, there was nothing to do but to follow obediently, getting thoroughly soaked as we trudged after him in the pouring rain. With improved drainage, landslides are a rare feature in Darjeeling now-a-days.

The gardens are a glory. They are all very nicely laid out. Familiar flowers in great profusion meet the eye at every point. Many new and strange varieties are also to be seen. The red church spires here and there lend an inspiring touch. No matter where one goes one comes across some token of honor to God. To make the scene still more picturesque there is a background of snow-capped mountains, which change their pure white color to a dress of fiery pink at the rising or setting of the sun. Kanchenjunga seems very near; it is somewhere in the region of 27,000 feet in height.

Tibet

Afar off can be seen the mountain pass which leads into Tibet, the forbidden land. I have looked across and thought about a woman's hospital there as I wondered what the poor creatures did when in need of hospital care. The Grand Llama, or Dalai Lama, has had a baby Austin brought to Lhasa. It is painted with his own colors, red and yellow. It was driven up to Darjeeling and then carried over the mountain by relays of 30 coolies. He has had it numbered Tibet No. 1, and has had a Chinese chauffeur especially trained to drive and look after it. Someone suggested Tibet No. ½ would have been a big enough number for such a small car. Some years ago the Grand Lama imported a car, but the people thought a devil must be in it to make it run by itself, and he had to give it up.

WOMEN OF DARJEELING AS WE MET THEM

Prayer Wheels

The Tibetan Buddhists carry a metal casket attached to a stick which can easily be sent spinning round and round. Inside is a prayer written on paper and if during life they walk 5,000 miles saying, *"Om, Ma, Ki, Pad, Mi, Hung,"* they are sure of reaching heaven. *Om* is the region of the gods, Dewa Lake; *Ma,* the region of the demigods or Asura; *Mi,* the region of holy spirits or Preta Loka, and *Hung* the region of hell or Naraka. Such is the belief of the more simple, but when we inquired of an old Tibetan if he really had faith in such teaching he replied, "One must do good and avoid evil." His practical belief appeared to be the keeping of the Ten Commandments, of which he had never heard. It is said that outside one of the Buddhist monasteries there are many large prayer wheels which are kept in motion by a lama who runs around followed by his fellow monks. In this way the required 5,000 miles are soon covered.

They also believe that, if a man recites the above mentioned Six Sacred Mantras daily, innumerable human beings are freed from the misery of the six regions and will be reborn in Dewa Chen, or the "Happiness of Bliss."

"Prayer-rags" are also to be found in Tibet. An old rag is attached to a stick. From constant exposure to the elements it becomes even more dilapidated. This stick is stuck in the ground and every time the rag sways in the wind, why—that is another prayer. It seems an easy way of getting a large number of prayers said and yet it is strangely reminiscent of the practice of consecrating one's every action to God.

The "lay Buddhist-man" looks exactly like the villain in a Chinese play. He wears a little round hat and a long silken coat. Nearly all grow a mustache, short over the lips and drooping at the sides. The national form of footwear has disappeared in favor of that from Europe, which is worn with the back tab showing and usually without stockings. It is a very incongruous sight to see most of the hill-women prettily dressed in Oriental costumes, bare legs (mostly), heavy silver anklets and smart, good-looking European shoes.

The young Buddhist girls smear blood on their faces in order that the lamas will not find them attractive; at first sight it is a very unbecoming facial adornment and quite repulsive when one finds out what it really is. Otherwise, they are extremely pretty.

Tibetans are said to have very good manners, and the most polite salutation used to be to take off the hat, *put out the tongue* and make a profound bow. I do not know if that is still done in Tibet. I was anxious to see such a meeting, but was disappointed.

Inhabitants of Darjeeling

The inhabitants of Darjeeling consist mostly of Tibetans, Nepalis, Bhutans, a few Bengalees plus a sprinkling of Mohammedans, the latter having come from distant parts to sell their wares at exorbitant prices (for India) to unsuspecting tourists. There are quite a number of Kashmiri shopkeepers who have brought their rugs, cushion covers, carvings, etc., all the way down from Kashmir.

Most of the people have little, slant eyes, yellowish-golden complexions, bright pink cheeks and

very straight, long black hair, often done in a pig-tail hanging down the back. (Some of the men also have long pigtails.) With their brightly colored dresses and graceful veils, they make a very pretty picture, more Chinese than Indian.

Among the laboring classes most of the work is done by the women. They do all the coolie work—all day long running around the bazaar saying, "Coolie, *memsahib!* Coolie, *mensahib!* Take my picture *memsahib* and give me *bakshish!*" They are well used to posing for the tourists and getting *bakshish!* On their back, held in place by a band around the head, some of them carry huge baskets of stones or pineapples from away down in the valleys. One wonders at their strength! The baby or even a fair-sized child is also carried on the back in this way, sometimes in a little basket or tied on by means of a shawl. It is very interesting to watch the coolies. I shall never again eat a pineapple without being reminded of the Darjeeling coolies. They carry many other things on the back, but pineapples, babies and stones are their specialties.

White Plague

Many of the people suffer from tuberculosis, but not our strong, happy, healthy coolie friends. That may sound strange, for Darjeeling is a very healthy place. The trouble is that it is cold most of the year and the natives huddle together in tiny, dark, one-roomed, windowless houses; at least, the poorer ones do. Hence, when one member is attacked by disease the infection spreads very rapidly, especially as the floor, more often than not, serves as a bed, table, chair and, worst of all, a sputum cup. There is a plan afoot to stamp out this dread disease with the aid of our Society and the cooperation of the municipality. It would be a God-send to the people if it could be brought under control. For this trained nurses are required. There is so much to be done in India, but it needs people with health, good-will and endurance.

No Mother-in-Laws

We visited quite a number of native houses and were welcomed with very sunny smiles. One blessing here, as far as I can see, is that there are no mother-in-laws to cope with. We did not see one and whenever I inquired, I was told that husband, wife and children lived together. The old mother-in-laws, with uplifted hand, and their "ha ha" to all advice, are the bugbear of health and hospital work in India.

The Pahari language has to be studied; it is a mixture of everything: Tibetan, Nepali, Bhutani, Hindi, etc. Many of the people, even the women, understand Hindi, so we were able to speak with them, but no doubt the more secluded, higher caste people, will only be able to speak their own language.

Nepal

Nepal, another "forbidden land" is quite near by. From Kursong, a few miles down over the mountains, we stood, facing it across the valley, only three miles distant. The Jesuits at Kursong have a lovely Sacred Heart statue, with arms outstretched, looking in the direction of Nepal. As we gazed across the same prayer came to our lips: "Just a little hospital for the women."

There is a story of two Nepalis who became Catholics and, after some time, decided to return to their own people and were never heard of again. About that time word leaked out that two travelers had been killed on the road, just inside the kingdom, and it is believed these Catholics were the two. Surely two martyrs ought to get us a hospital! Nevertheless, the hill people have very nice ways, and gentle, sweet voices, and are said to be very grateful for any kindness and never forget it. Once they are converted, they remain very good, staunch Catholics and, what is more, go out and bring others into the fold.

WORDS OF THE HOLY FATHER TO OUR MISSIONARIES:

"It is a joy to see the Medical Missionaries, particularly as my great desire is to have and to foster public interest in Medical Missions, and you are carrying it into effect. The Medical Missionaries respond to my thought and desire, for in many cases souls can be reached only through bodies."

WORDS OF HIS EMINENCE, CARDINAL VAN ROSSUM:

"The example of our divine Redeemer Who united Himself preaching with healing the sick and the word He spoke to the Apostles when He sent them forth preaching: *Curate infirmos qui apud illos sunt,* show clearly how necessary is your contribution to the great work of extending the Reign of Christ on earth.

"I am really satisfied with the development your providential initiative has taken, and I hope that this progress will continue always more: the needs in this regard are immensely above the help of which we dispose. Your work will excite many young people to follow your example and to devote themselves to this apostolate."

Addresses of Our Missionaries:

In the Punjab: The Holy Family Hospital, Murree Road, Rawalpindi, Punjab, India.

In Bengal: St. Michael's House, Segoon Baghan, Ramna Station, Dacca, Bengal, India.

In England: St. Helen's, Winchcombe, Gloucestershire.

THE SOCIETY AT HOME AND ABROAD

MEDICAL MISSIONARIES AT HOME

WASHINGTON

The extraordinary mild weather has preserved the autumn glory of our surrounding woods unusually long this year, much to the delight of us all; especially of our new candidates, who think so far at least that the Washington climate is just ideal. We old-timers tell them: "Wait and see."

As in other years, the Holy Cross Fathers very kindly are giving the religious instruction to us, and thanks to them also we have Holy Mass every day in our chapel. Our little chapel is now not only filled to overflowing, but the overflow actually has to remain in the corridor. However, we are glad to put up with the inconvenience, as our need is missionaries and more missionaries. Every day we say three Hail Mary's with the invocation: Our Lady, Cause of our joy, pray for us, for an increase of vocations. You would be one of our great Benefactors by saying this prayer every day for this, our most important intention.

ENGLAND

With the permission and encouragement of His Eminance Cardinal Bourne, we opened on October 3 the Feast of the Patroness of Missionaries a small house in England. This progress was made possible by the generosity of Miss Pauline Willis, an old friend of Medical Missions, who kindly lent us her lovely cottage: St. Helen's, in Winchcombe, Glo., until we can find suitable permanent quarters.

ST. HELEN'S, WINCHCOMBE, GLO., WHERE WE MADE A START IN ENGLAND

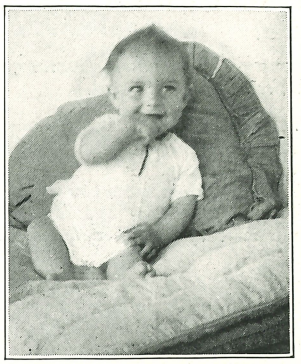
DACCA

For two and a half years Sister M. Laetitia and Sister M. Helen have been engaged in visiting the homes of Dacca to help mothers and their babies. Lately, authorities of the Municipal Hospital asked Bishop Crowley for two Sisters of our Society, one to be the Superintendent, the other the Assistant Superintendent of Nurses. As he hospital has 700 beds, it is a big task, and we ask our readers to pray that our Sisters may be able to instill into the native nurses the high ideals of the nursing profession.

RAWALPINDI

Dr. Lyons writes:

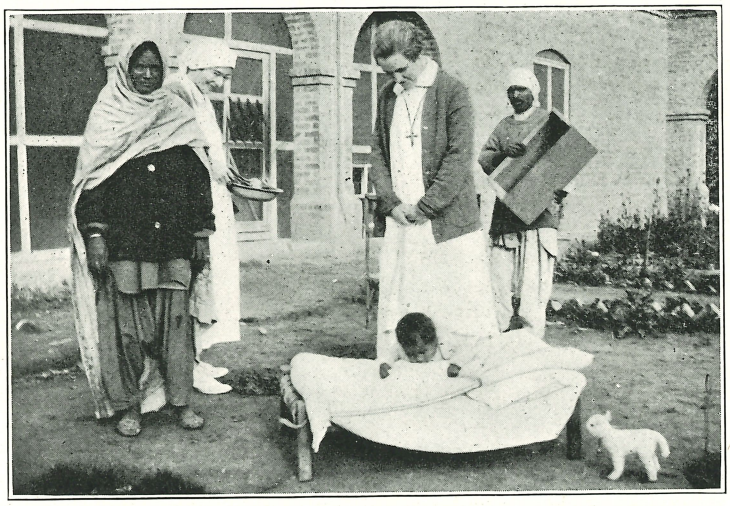
"Our latest purchase is a water buffalo. She is fat, clumsy, nervous—when white people are around—and half wild and wholly awkward. But her milk is a treat. Milk here was quite expensive, and was apt to be far from clean. Included in the purchase price was a necklace of large, blue beads, which she wears day and night."



First baby born in the Hospital. David is now four years old.

Whatever you do to the least of these, you do it unto Me.

The baby was brought just in time to receive the baptismal robe of innocence to swell the number of little angels in heaven.



WATCHING HIS FIRST STRENUOUS EFFORTS

May we ask you to remember our work for the sick in the Missions as generously as possible in your Christmas gifts. May the Infant Jesus bless your charity abundantly.

Student nurses at the Holy Family Hospital introducing Stephen to his first Christmas tree

THE ROLE OF MEDICAL WOMEN IN EXOTIC COUNTRIES

By Dr. Margaret Balfour, *C.B.E., M.B.*

(Resumé of the report presented at the sixth International Convention of Women Doctors, held in Vienna, from September 15 to 22 of this year which the Editor attended.)

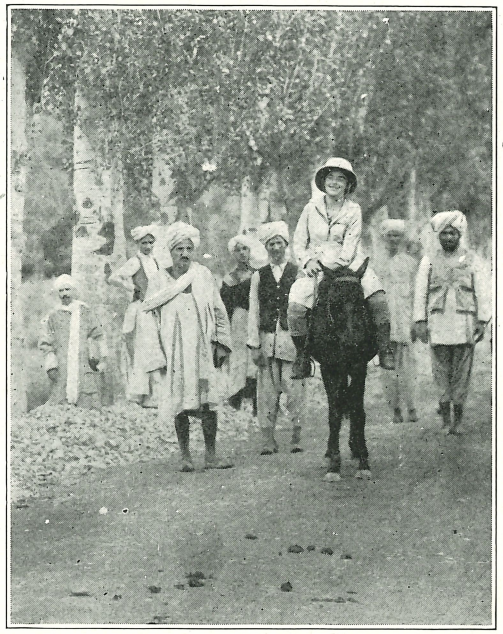
A QUESTIONNAIRE addressed to medical women was issued by the Central Office and National Corresponding Secretaries of the International Association of Medical Women, and replies were received from 40 medical women working in India, the Dutch Indies, Persia, Malay, China, Japan, Egypt, the Soudan, Palestine, Hongkong, Trinidad and Africa.

The subject of the questionnaire will best be considered in two parts: The special needs which require the presence of medical women in exotic countries and the extent to which these needs are being met and should be met more fully.

The special needs which require the presence of medical women in the exotic countries mentioned are: Habits and customs of the people, maternal mortality, infant mortality and miscellaneous needs.

Habits and Customs of the People

The most urgent of these is the *purdah* system, which prevails in India, and under which women are kept secluded in their houses and are not allowed to show their faces to any man other than a near relative. This means that they may not consult men doctors, or attend hospitals with male patients or staffs. They cannot show themselves to a male doctor, and cases have occurred where they preferred to die rather than do so. Purdah is most common among the Mohammedan population in India and less common among the Hindu. In many parts of the country Hindu women are quite free of it. It is estimated that out of a population of 120,000,000 women about 30 millions keep purdah. But there is no doubt purdah is less than before and that many families, who observed it formerly, do not do so now. Others still observe it, but less strictly; they will on occasion consult male doctors, though with restrictions and precautions. The orthodox still keep it strictly. Purdah does not occur so severely in other countries with Mohammedan populations, such as Persia, Egypt and Palestine, but even there it is the custom for Mohammedan women to be more or less secluded and attendance by their own sex is essential. This preference which women have for attendance by their own sex, quite apart from purdah, especially in matters connected with obstetrics and gynecology, is emphasized in the replies from the great majority of the countries.



SETTING OUT ON A SICK CALL IN KASHMIR

From India "The habits and customs of the people of India make it not only advisable but essential to have medical women."

From the Dutch Indies "Their religion does not forbid native women to be treated by male doctors, but I know from my own experience it is much easier for a medical woman to be admitted than it is for a man. And when the woman is in danger she will not object to a man's help, but if she is not in danger, she mostly will not consent to go to a male doctor to be examined."

From Persia "In a Moslem country like Persia men are not allowed to see a woman's face if she is not of their own family. This means that any examination, which is needed, very seldom takes place."

From China "Very advisable to have women doctors, because of feelings of modesty on the part of the patient—not absolutely necessary."

From Africa "Native women would never accept treatment from a man were a woman available, as all their manner of life and their reticence leads to this preference."

From Palestine "The seclusion of Moslem women (about 7.5 percent of the whole) makes it very advisable to have medical women. Otherwise many of them are out of reach of medical treatment."

From Egypt "The majority of women (both Moslems and Christians) dislike going to men doctors. The majority of men dislike having their women attended by men."

From the Soudan "The harem customs among the Moslem population makes a woman doctor necessary for all women's work."

A custom which is often commented on, especially as regards India, is early marriage. It is noteworthy that, although 10 medical women from India have replied to the questionnaire, none have mentioned early marriage as an important factor in maternal or infant mortality. This does not mean that early marriage does not occur, and that it does not sometimes lead to deplorable consequences, but it indicates that it does not bulk largely as a cause of maternal and infant mortality in the general population.

The general habit of life which is so common among the Moslem races is well described in a paper from the Soudan. "The woman of the Northern Soudan is a lady of large dimensions, whose ambitions in life are to be fat and to have children. She begins life as an adorable brown baby and becomes a slim and attractive, graceful, small girl with beautiful manners. At the age of 10 the tribal marks are cut on her face with a razor. A short time later she becomes hareem and is a prisoner within the four walls of the mud compound. She is now being fattened and prepared for marriage, which, with luck, takes place at 15 or 16. From 20 to 30 she is busy bringing children into the world. Soon after 30 she becomes a grandmother and as such she takes over the charge of her daughter's children, whom she looks after well, according to her lights. These lights, in most cases, consist of allowing them to feed on dates, native bread, etc., and if convenient, to nurse them. When remonstrated with, she says, "What can you expect, we are only cattle." Not only is there an appalling waste of infant life and health as a result, but also, there is an equally appalling waste of womanhood.

Other factors encountered, which have to be contended with, are described in various papers as ignorance of the people, poverty and malnutrition. A writer from Hongkong reports that a number of people among whom inquiry was made, had a sum equivalent to $1 per head, per month, for all purposes. Similar facts might be given from India and, no doubt, from other countries.

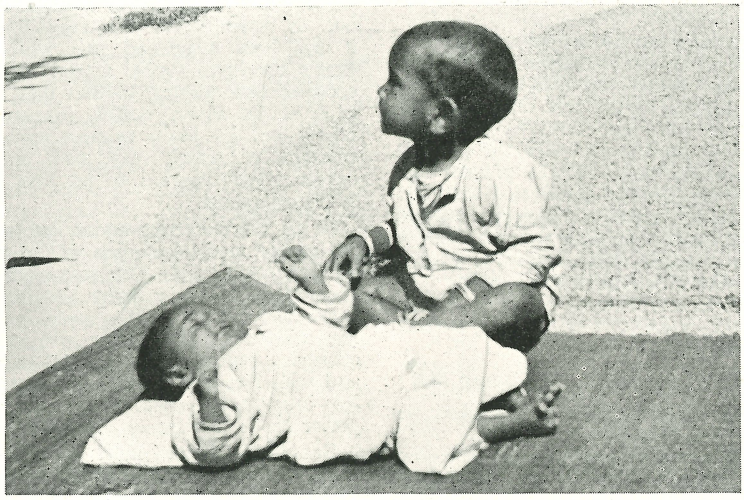
Maternal Mortality

There is a certain uniformity in the replies to the questionnaire on the subject of attendance in labour. All state that the attendance is mostly by untrained midwives. From the descriptions given, the Indian dai, the Dutch Indian dukun and the African untrained midwife (and the untrained midwives of other countries) all bear a close family resemblance. In Africa "their only qualification needs to be that of marriage and to be the mother of a child." In Persia the women think something has gone wrong if they do not get fever following a confinement. The native midwives of course are at the root of it all, filthy and ignorant. In India (where the dais often form a hereditary caste) unskilled attendance causes death through failure to recognize abnormalities, unnecessary interference in normal cases and lack of aespsis. Owing to the great delay, both mother and child suffer and frequently die.

A paper from Sierra Leone says "In the Protectorate women will not go to hospitals as inpatients; for one thing there are no women nurses to look after them. They never have men doctors in their own homes."

Diseases known in Europe, such as eclampsia and hemorrhage occur. In addition anaemia is common. This appears as an acute condition and is believed to be connected with nutritional factors. It is at present under observation. It is a large cause of maternal deaths in India. Similar conditions are reported from Malay, Africa, and Hongkong.

Osteomalacia (softening of the bones) is reported from many parts of India and from China, also from Egypt. One case is reported from Tanganyika, in East Africa. The disease has been investigated both in India and China. Particulars are given of one district in the Kangra Valley where an investigation was made. Fifty-one percent of the people were affected with some degree of rickets or osteomalacia, although they had abundant sunshine. The diet was poor. This disease sometimes leads to deformities, with grave consequences.



WE ALL LIKE TO SEE BABIES HAPPY AND WELL. TO KEEP THEM SO TAKES INTELLIGENT CARE.

Beri beri is reported from South India, Malay, the Dutch Indies, Japan, Hongkong.

Malaria is a serious complication in most exotic countries. This is especially emphasized in papers from West and East Africa. One writer says that 85 percent of the children suffer from enlarged spleen, and malaria, often quite untreated, is a large cause of maternal mortality.

This question of maternal mortality is one of importance, and means an enormous wastage of life. In India alone there are approximately 8,000,000 births annually, and if we take the maternal mortality, as shown in the Murshidabad investigation, at 12 per 1,000 births, the maternal deaths work out at over 100,000 annually.

Infant Mortality

The rate of infant mortality is not so difficult to ascertain as that of maternal mortality, but even so, those who have attempted to supply the information, do it with an element of doubt. In some of the countries, laws have been passed requiring the registration of births, and local bodies are empowered to adopt these laws or not as they see fit. Even where such laws are adopted, they are not always enforced by penalties. In certain of the large towns of India great efforts are made to get correct vital statistics, and a special staff is kept who pay house to house visits and so collect the information.

In other countries different methods are employed. Thus in Tanganyika (E. Africa) efforts are being made to get correct vital statistics by keeping one area under close observation. Balls of colored string, each representing a different class and age, are issued to the headmen of villages; the people file before them and a knot is made on the correct string for each person. This gives an idea of some of the difficulties of getting information, where the people are illiterate and the government is short of funds.

In most of the countries the infant mortality during the first month is estimated as one-third to one-half of the mortality for the first year.

Where statistics are so unreliable and medical certification of death is lacking, except in a few cases, it is not possible to get much definite information as to causes, but nearly every paper expresses the opinion that infant mortality is high. Different writers mention as causes difficult childbirth, ignorance of mothers, prematurity. Tetanus is given as a cause in China, parts of Africa and parts of India; beri beri in Malay, the Dutch Indies, parts of India, parts of Africa and Hongkong. Malaria is referred to, especially in Africa. Of the Gold Coast it is said "malaria (indirectly) is probably the great cause of infant mortality, because of the very severe anaemia which accompanies it in babies." Of Sierra Leone it is said "the cause of deaths, either directly or indirectly, in the majority of cases appeared to be malaria . . . 85 percent of school children had enlarged spleen." The importance of premature birth as a cause of neonatal death is put forward and the suggestion made that it may be concerned with a nutritional factor.

The movement known as Maternity and Child Welfare for the prevention of disease in mothers and children has only opened out in exotic countries during the past 15 or 20 years. In some cases it began by the efforts of medical women in connection with their hospitals, while in other cases it was commenced by lay workers.

In India, after a number of scattered beginnings, a School for Training Health Visitors was opened by a voluntary association in Delhi in 1918. There are now seven such schools in different parts of India and many Indian and Anglo-Indian Health Visitors are in charge of centers in different parts of the country, although the number is small compared to the population.

In China, child welfare work is being carried on in connection with some missions and also by government and some local bodies. There are two child welfare centers in Peking—one in connection with the Union Medical College, the other under the municipality and run by the medical women of the midwives' school already described. Both are very successful.

In Malay and in Africa, child welfare work is carried on both by missions and by government.

In Palestine, the work was begun after the war by Jewish organizations and other communities, seeing the good results, followed suit. Government now also carries on centres, but employs no medical women. It has been urged to appoint a medical woman especially for the supervision of newly trained midwives, but so far has not done so.

In Egypt, infant welfare work is carried on by government as well as by missions.

In Trinidad, it is carried on by government, and charitable organizations. In Hongkong, chiefly by charitable organizations, but government is said to be maturing plans for its furtherance.

In the Dutch Indies, Persia, and Greenland, infant welfare has not yet developed to any extent.

Miscellaneous Needs

Under the heading of Miscellaneous Needs comes research, especially in connection with obstetrics and infant mortality, also in connection with women's industries. There is also medical inspection of school children, employment in connection with jails and mental hospitals and administration.

India is rapidly becoming an industrial country and women are being employed in increasing numbers in China, Africa, Malay, and Japan. In 1922-23 an inquiry was made into the conditions of the jute and cotton industries, so far as women were concerned, by two medical women in India, who were loaned, for the purpose, by the Women's Medical Service. At the present time two medical women are employed in connection with factories in India, one with the status of factory inspector in Bombay, the other in connection with welfare work in Nagpur. There are also some welfare centres in factories under Health Visitors (although very few).

It is also important that experienced Medical Women be employed to organize medical work among women and children and to inspect existing work.

The Extent to Which These Needs Are Being Met

We now come to the question—how is the need for medical women being met?

In India, China, and in the Dutch East Indies a limited number of medical women are in government service and a few are employed by provincial governments.

A fair number of Indian, Chinese, and Japanese women study and practice medicine.

A considerable number of medical women are working in connection with Christian missions. There are 229 such women with degrees or diplomas of the British Empire, of whom 155 are working in India, and there are others, though fewer in number, holding degrees and diplomas of other nations. Those who have replied to the questionnaire speak of the great interest of the work and of the urgent necessity for more workers if the needs of the women and children are to be met at all adequately.

(Editor's Note: In recent years several Catholic medical women have begun to work in the mission fields but the supply in this respect falls very far below the demand. Apart from the spiritual side of the question, the medical mission field offers one of the most interesting and useful careers to be found in the world.)

In the older countries, such as India and China, a fair number of medical women are in private practice, but almost entirely in the larger towns. As a general rule the people are too poor and not sufficiently enlightened to make private practice possible in the villages. This touches on an important question, the crying need for medical women in village areas, but one which is too large to embark on here.

The information shows that in all these exotic countries efforts have been made to provide medical aid by women *and that missions, espeecially, have done incalculable service;* but in all these countries there are still immense tracts without medical women and many millions who have no opportunity of consulting their own sex, even if any medical assistance is available for them.

Nearly all the writers speak of the need for more medical women, either directly, or indirectly by proposing to extend the activities. One asks that they should be "specially qualified." The services of some of these could be very well utilized by having centers for medico social work in large villages, which will form a nucleus for a group of villages all around. It is only when some such scheme is organized that medical relief to the masses will be brought well within their reach.

The preceding pages have shown that there is, in exotic countries, a great field for medical women and one which is, as yet, very inadequately filled. There is firstly, what may be called the essential services of obstetrics and child welfare, and secondly, general medicine and surgery, especially gynaecology, administration, research, school work, etc. . . . In these exotic countries the provision of medical women, not only relieves suffering, but helps to produce a better standard of health and to keep intact the principles of morality, in which many of the inhabitants have been brought up. Workers should have the best professional training and should have practical experience of their special branch of work before going out, as consultations are often impossible. In addition, it has been suggested that medical women going to exotic countries should attend some special course of a socio-medical nature, so that they may get some knowledge of the special habits, customs, beliefs and diseases which they are likely to meet with, and a lack of understanding of which may spoil an otherwise successful career. Such courses do not now exist and would have to be organized.

In all the countries under discussion, the first task of the earlier medical women was to organize some kind of nursing service. In this they sometimes had the assistance of European nursing sisters. Later, Governments came forward to assist, especially in the work of training midwives. There are now, therefore, in all these countries, especially in the older ones, a number of nurses and midwives belonging to the country, with a greater or less amount of education and training, but all very superior to the indigenous, untrained midwives.

But the poverty of most of the people makes it difficult for them to employ educated midwives, even if they were enlightened enough to see the advantages, which, in most cases, they are not. Moreover, in these vast areas of country, where educated and enlightened people are few, or altogether lacking, it is not safe to send young women to work alone in villages. Apart from that, in most of these countries women are in a minority, so there is no class of unmarried women who can make work their first objective. For these reasons medical women, in dealing with people outside hospitals, must make all possible use of married women and must even avail themselves of the services of the untrained midwives. In India many efforts have been made to train these women and the concensus of opinion is that improvement can be effected, if it is to be in any way permanent, their work must be kept under supervision.

In China, it is stated, a comprehensive scheme for the regulation of midwives' practice is shortly to be carried out. A training school for midwives was opened by the Central Chinese Government of Peking in 1929. This is under the charge of two Chinese medical women, assisted by a Chinese nurse who has the English C.M.B. diploma.

It is the intention to open four other Central Schools in large towns in addition to 21 Provincial Schools, one for each Province of China and to train during the next 50 years 100,000 midwives.

Many medical women are entering the ranks of the medical profession every year both in Western and Eastern countries and a number of them are willing to take up work in the Orient and Africa. It is to be hoped that many governments will give the help needed for carrying on this work and thereby relieve the conditions of the women in exotic countries.

DISPENSARY DOINGS

By Dr. B. K., *Holy Family Hospital, Rawalpindi*

SHOULD you be interested in a picture of our dispensary as it appeals to me, here goes. One side of the room is taken up with two small cubby holes, partitioned off from the remainder of the room, for examination and treatment of cases. A small medicine closet is between these partitions. One of the small rooms has a window which is glazed over. On the opposite side of the large room is a heavy flat topped medical table in which our case records are kept and upon which our histories are written. Above the table, is a large crucifix. There are no other pictures in the room. On one side of the table is my chair. On the other side, is a weary looking rocking chair. Half of the seat is gone from it, but I wouldn't relinquish it for worlds. It is a very pleasant help in time of trouble. The seat is so low and also so deep and capacious that whoever sits in it once, can not easily rise again: the chin is below the level of the table, and the occupant is sunk into semi-oblivion. He can neither see what I am about to do nor can he raise his voice with any feeling of haughty power to hastern his turn in clinic. Into that chair, all the very ill or very noisy cases are deposited till I have time to attend to them. The ill go there because it is a restful and quiet place to stay while their room in the hospital is being prepared for them. The opposite sides of the room contain a door each, and one of the sides is a window. The window is usually open for light and coolness. It is frequently lined with four or five faces of strangers who are waiting on the porch for their turn to come to be taken into clinic, strangers who simply *must* see what I am doing inside or die of curiosity. They tell those near them what actions of interest have taken place. The inside door which leads into the hospital is rather a nuisance sometimes, because the in-patients pass through the dispensary time and again to see what I am doing or to get water for their relatives. The dispensary is a short-cut to the fountain outside. Some forget to pass on for water, but stand all ears and eyes watching my work. Others come to tell me that the medicine they have already received in the house that morning was not what they desired; they wish more medicine or other medicine, or they have just discovered that same new ailment has cropped up. So that inside door is occasionally locked. When locked, the insiders hammer on it imperiously or push it so hard that it opens. And to my query as to what they required, they cooly remark that they just wanted to look around. So far for the inside of the room. By the window there is a bench on which a few patients can wait. The patient I am seeing sits on a stool near me, her nearest relative occupying another stool. All others must stand or sit on the floor. There are only the short bench, two stools, my chair, and the aforementioned rocker available for sitting purposes. Outside on the verandah, the patients line up waiting to be seen. With each patient there are usually one to two relatives, sometimes the whole family. As the majority can neither read nor write, it is an event of great interest and a place of interchange of news enough to last for several days to have visited a hospital. That is the reason why some come, others because it is not well to go about in India alone, unchaperoned. The Mohammedans take their *burkahs* off on the verandah and leave them there, so I cannot always tell whether my patient is Mohammedan or Hindu. On the verandah are two long benches on which the patients sit. The floor is cement, the arches and roof are tile and brick. Looking through the arches, one sees the whole compound, the garden being within a few feet, and the air being sweet with the smell of roses. The arches are covered with rush matting when the great heat is on. But the Indians rather like heat. They are all cheerful, patient, friendly, kindly. They go to the dispensary window for their tickets, and in that way we are able to know who came first and whom to call first. But should a very ill patient appear, they do not hesitate to see that she is taken care of first. It interests me that the Hindus, Parsees, Christians, and Mohammedans sit side by side with no desire to move from each other, and that they talk together in a friendly way.

After I have made my rounds with the sister in the hospital, dispensary begins.

The first case to come today was Job. Job is a boy of 14 months who have developed boils. Sister says it is dirt; I think it is diet. Anyhow, boils are boils, and he has plenty of them. Since they arrived coincidently with his mother's putting him on buffalo milk, I have cut the milk out of the diet and fomented and lanced the boils.

WAITING ROOM OF OUR DISPENSARY WHERE MUTUAL SYMPATHY PROMOTES FRIENDLY INTERCOURSE WHICH OVERCOMES THE TRADITIONAL BARRIERS OF CASTE AND PREJUDICE

It is this child's fourth visit: and does he ever recognize me! He can spot me a block off. Not with love! But he really is improving rapidly. It takes two of us to hold him when he hears my voice. And some one told me that infants remembered nothing!

In the meantime, number two who has come to have a wound dressed, is lying full length on the bench with everybody inspecting said wound. On the whole, it is a bit embarrassing as the wound has taken over a month to heal; but you should have seen the woman when she entered! She looked like a famine victim, and seemed ready to die. Now she is almost fat, is getting rosy, and grins from ear to ear, and advertises the hospital wherever she goes.

Number three sits on the floor with two children: one is three years old, clad in a short shirt only, and intensely dirty. The other is about five and has eyes swollen shut with trachoma; her hair is matted with dirt; and she stares at the picture of Christ, awe-struck. The mother spits *pan*, a dirty staining nut used as a substitute for gum in India, all over the floor. She has left her shoes outside; but people often go barefoot here. The grandmother tries to kiss my feet while I am attending to Job, in order to win leniency from me. So I keep my feet under the desk, where the mosquitoes bite my legs. And, as the bones in said legs still ache a bit from my last bout of malaria, out come the legs again in a hurry, and get kissed, which I do not approve of. In the meantime, baby aged three is soundly slapped by his mother for pulling the mothers hair or ear-rings too hard. And he howls and howls. So I go on to number four, telling number three that I will see her as soon as her young hopeful has been pacified.

Number four has Tb. I love to listen for Tb when there is a howling infant in the room—not! She has had a cough and fever for several months, but that is not what she came for. She came because she has had no children. Would I please give her such a medicine that she would have a son, so that the father might call her blessed and die the proud possessor of a son who could conduct his funeral rites for him. Her gold ear-rings, ornamented with rubies and pearls, tinkle from her ears; her sari is of the flimsiest purple crepe, the shoes of gold lace and leather, turned up at the toes. She is a little beauty, but sad.

And so it goes, to the tune of forty or more cases a day. I love them all, clean and dirty, rich and poor.

MISSIONS MOST NEEDFUL IN TIME OF STRESS

In a sermon, preached on the feast of Christ the King, in aid of Missions, Rev. Bede Jarrett, the well known Dominican preacher and writer, said: "But why foreign missions in these times of stress and anxiety and need for economy in every direction? Why send out these priests, scattering them world-wide, without assured means of subsistence, to evangelize these pagan nations? Why not apply our resources and energies entirely to the needs we see around us, and at our very doors? Surely there is ample scope for us here.

"Because," he said, "the Kingdom of God on earth is all the more important for the well-being of man even on the merely human side, when human effort and skill seem to be losing ability to hold their own against the opposing forces which threaten to submerge the nobler aims of mankind. It is for us to work the harder in opposition to the enemies of Christ, whose Feast as King we are keeping today.

"In the history of the world, we find that the greatest empires were being built when the foundations of the ancient civilizations were crumbling."—The Universe.

THE SOCIETY OF CATHOLIC MEDICAL MISSIONARIES

THE Society of Catholic Medical Missionaries was founded in September, 1925, in Washington, D. C., with the approval of His Grace, Most Rev. M. J. Curley, D.D., Archbishop of Baltimore. The Society is designed to meet the need existing in all parts of the foreign mission field for Catholic medical women, willing to devote their life and profession to the service of the suffering millions in Pagandom.

It is intended for qualified women: Doctors, dentists, nurses, pharmacists, dietitians and technicians, etc., who feel attracted to the religious life, and who wish to continue to practice their profession in the service of God as foreign missionaries. These will find ample scope for their generosity in the Society of Catholic Medical Missionaries, whose purpose is to render medical aid, no disease or condition being excepted, to Christians and non-Christians, and to bring the light and consolation of our Holy Faith to the people under their care.

The Society will also accept members who possess no medical qualifications, either with a view of training them in some branch of the profession after admission, or with a view to devoting themselves to non-medical work inevitably connected with the undertakings of the Society at home and abroad.

The requirements for admission are the same as for other religious communities.

Please address inquiries to Dr. Anna Dengel, *Catholic Medical Mission House, Brookland, Washington, D. C., U. S. A.*

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